# NC DMA Pharmacy Request for Prior Approval
# Narcotic Analgesic

**Recipient Information** **DMA-0015**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

**Payer Information**

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

**Prescriber Information**

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information: Name:_____ Phone #:_____ Ext:_____

**Drug Information**

9a. Drug Name: _____ 9b. Is this request for a Non-Preferred Drug? ☐ Yes ☐ No
10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:_____

**Clinical Information**

**If the requested daily dose is greater than or equal to 750mg of morphine or an equivalent dose, the request will be denied.
1. Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? ☐ Yes ☐ No If yes, the patient is exempt from the prior authorization requirement
2. Has the prescriber reviewed and is adhering to the N.C. Medical Board statement on the use of controlled substances for the treatment of pain? ☐ Yes ☐ No

Criteria for Use of Short-Acting Narcotic Analgesics:

Preferred Products:

3. Is the requested daily dose less than or equal to 750mg of morphine or an equivalent dose? ☐ Yes ☐ No

Non-Preferred Products:

4. Is the requested daily dose less than or equal to 750mg of morphine or an equivalent dose? ☐ Yes ☐ No
5. Does the patient have a documented history within the past year of a 30 day trial of a preferred short-acting Narcotic Analgesic at a dose equal to or equivalent to the non-preferred short acting Narcotic Analgesic being prescribed? ☐ Yes ☐ No
Please list: _____
6. Does the patient have a contraindication or allergy to ingredients in the preferred product? ☐ Yes ☐ No
Please list: _____

Criteria for Use of Long-Acting Narcotic Analgesics:

Preferred Products:

7. Does the patient have a diagnosis of chronic pain syndrome of at least 4 weeks duration? ☐ Yes ☐ No
8. Is the requested daily dose less than or equal to 750mg of morphine or an equivalent dose? ☐ Yes ☐ No

Non-Preferred Products:

9. Does the patient have a diagnosis of chronic pain syndrome of at least 4 weeks duration? ☐ Yes ☐ No
10. Is the requested daily dose less than or equal to 750mg of morphine or an equivalent dose? ☐ Yes ☐ No
11. Does the patient have a documented history within the past year of a 30-day trial of a preferred long-acting Narcotic Analgesic at a dose equal to or equivalent to the non-preferred long acting Narcotic Analgesic being prescribed? ☐ Yes ☐ No
Please list: _____
12. Does the patient have a contraindication or allergy to ingredients in the preferred product? ☐ Yes ☐ No
Please list: _____

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

Fax this form to CSC at: (855) 710-1964 Pharmacy PA Call Center: (866) 246-8505

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp

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